MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

63-017475
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3686

FILED APR 17 1963

DO NOT WRITE ON THIS STUB | AMENDED

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | INSTEAD OF | SHOULD READ | BY AFFIDAVIT OF | DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): ST LOUIS,
Length of stay in 1b:
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 4103 a WEST LEE
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY:
c. CITY OR TOWN: ST LOUIS,
Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 4103 a WEST LEE
Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First MARTIN Middle R. Last CAVANAGH

4. DATE OF DEATH: Month Day Year MARCH 28, 1963

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. Married ☐ Never Married ☐ Widowed ☐ Divorced XX

8. DATE OF BIRTH: 11/17/1909

9. AGE (last birthday): 53
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): ST LOUIS MISSOURI

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: MARTIN W. CAVANAGH

13b. MOTHER'S MAIDEN NAME: ALICE FOLEY

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): WORLD WAR 2

16. SOCIAL SECURITY NO.: [redacted]

17. INFORMANT / Address: ADELINE NAPPER 2106 SUN VALLEY D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Oedema of lungs;
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Congestive Heart Failure.
434.1
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION / COUNTY / STATE

21. I attended the deceased from ______, to ______ and last saw her/him alive on ______
Death occurred at 3 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Joseph L. McQueen (Degree or title) Deputy Medical Examiner

22b. ADDRESS: 1300 Clark

22c. DATE SIGNED: 4-1-63

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 4/1/63

23c. NAME OF CEMETERY OR CREMATORY: CALVARY CEMETERY

23d. LOCATION (City, town, or county) (State): ST LOUIS MISSOURI

24. FUNERAL DIRECTOR / ADDRESS: STROOT - CARROLL 4600 NATURAL BRIDGE

25. DATE RECD. BY LOCAL REG.: APR 1 1963

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed M W Richter

Licensed Embalmer No. 4865

P. O. Address St Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.